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Intersectionality and Community Engagement: Can Solidarity Alone Solve Power Differences in Global Health Research?

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Engagement is becoming increasingly expected in global health research. During the 80s and 90s the rate of production of literature on participation and engagement surged following research policy changes that mandated public participation or specific health scares that sparked public critiques (for a more thorough review, please see Reynolds and Sariola 2018). The recent interest in community engagement in global health research has followed an increasing ethical mandate of engagement. While the total literature on participation in health research and policy is too voluminous to summarize in this commentary, current literature in global health engagement is predominantly descriptive of the kinds of participatory practices that have taken place in global health research programs, and their ethical challenges. Critical analyses that have cross-pollinated the engagement literature concerned with participation in projects based in the Global North and development programs based in the Global South have been slow to emerge, with the former usually reported in the field of Science and Technology Studies and the latter within Development Studies. Additionally, philosophical and conceptual analyzes regarding the strengths of the arguments, the underlying notions of, and claims about engagement, have also been slow to emerge.

The article by Pratt et al. (2020) aims to fill some of these gaps. The authors describe three key goals of engagement: the instrumental, intrinsic, and transformative, and cite the promises of engagement for global health research. Literature that underlines the value of engagement for global health research often claims that engagement might be able to democratize knowledge production, be empowering to participating communities, and prevent malpractice etc. These are aspirational and indeed important outcomes.

In my social scientific work analyzing social relations of international research collaborations and their ethics, including engagement practices, I have reported the important and life-changing work that engagement practitioners and researchers working in international research centers in low and middle-income countries are doing. In addition, I have demonstrated that engagement in practice can fall considerably short of the ideals ascribed to it. What I mean by this is that the discourse and aspirations of engagement can promise more than what engagement delivers in practice. I have shown that the everyday implementations of engagement not only lead to neutral, or researcher-serving outcomes, but in fact, can be outright detrimental to those who the engagement practices are involving. With colleagues, I have shown that both international biomedical research and community engagement programs can inadvertently, and unintendedly cause harms, especially for vulnerable populations (Molyneux et al. 2016), or coerce people into research (Nyirenda et al. n.d.). These dynamics follow from power differences between researchers and communities or within communities themselves when research is conducted in low and middle-income countries; and insufficient time and other resources invested in the engagement process. This claim should not be read as a critique of engagement; the aspirational goals of engagement presented across the literature are important drivers for mandating more funding and momentum for conducting engagement. However, there do remain some crucial and unresolved practical and conceptual challenges and I propose that intersectionality might be a helpful concept for putting the power dynamics on the table more centrally.

Intersectionality is a concept, or approach, that has emerged from Black Feminist social movements and theorizing, most notably associated with the scholarship of Prof. Kimberlé Crenshaw (e.g., Cho, Crenshaw, and McCall 2013; Crenshaw 2017).

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Intersectionality brings attention to how people are defined by differing positionalities in a society based on their gender, ethnicity or race, sexual orientation, ability, and class, etc. These are identities and positionalities that form overlapping positions of inequality and privilege. They are in hierarchical relations to one another according to which some people have more power in societies than others. While these dynamics are locally specific and historically contingent, it is broadly acknowledged that white men generally have more power than others, and women, racialized, non-heterosexual, transgender, and disabled people experience more vulnerability, socio-economic struggles, and health inequities (see e.g. Kapilashrami and Hankivsky 2018; Zeinali et al. 2019). Importantly, intersectionality is not just a theory of identity and difference, but a theory of oppression, exclusion, and power that encourages everyone to consider how social structures do not affect everyone in the same way.

Pratt et al. propose that one solution to close the gap between the ethical ideals and the practice of engagement would be to engage with solidarity. Their proposal is both prescriptive and descriptive. They suggest that solidarity should be included as the fourth goal of engagement (in addition to the intrinsic, instrumental, and transformative goals), and describe what solidaristic relationships might generate. Conceptually, I am compelled by the framing laid out by Pratt et al. who reach out beyond the notion of engagement to look for solutions for engagement problems: solidarity could be a way of ensuring that engagement is not just a tick-the-box exercise, but results in meaningful outcomes.

The paper is laudable in its critical acknowledgement of potential objections to their proposal, as well as about the absence of debate concerning the generalizability or applicability of engagement models. "*So far, no consensus exists on whether the ethical goals of CE in global health research should span the intrinsic, instrumental and transformative or whether the same ethical goals should apply in different types of global health research (e.g. genomics, clinical, health systems)*" (2). In my view, their reflexive approach could go even further. Any obliging ethical mandate of engagement is somewhat of a dead-end—if engagement is accepted as ethically obliging, the space for research that involves no engagement shrinks, making transformative or solidaristic research the only ethically acceptable possibility and research without engagement problematic, even unethical.

The ethical mandate to engage also closes in on itself with questions such as: "How to engage? Let's engage the communities to find out how they would like to be engaged," and "How to talk about the ethics of engagement if members of the community are not included in the discussion?!" I have argued that the solution for challenges of engagement is not to do *more* engagement. Pratt et al. offer no respite to these questions other than to suggest that the solution for power differences in global health research is to do engagement *better*. A key challenge embedded in ethical expectation of engagement is its vagueness on and inability to theorize power—the ethical expectation to engage, including the notion of engaging with solidarity that Pratt et al. propose, contains very little of how research should do away with power differences in practice. Bringing in social scientists, community and development workers, communications officers, and community-based volunteers to mediate the research–community–participant relations rests on their experience, ingenuity, and knowledge as well as their ability to build and mediate these relationships. Pratt et al. rightly acknowledge that the power differences within the social networks of researchers and participants are vast and suggest that forming relationships with local social movements that mobilize around health and allow participating communities to shape the research agenda could enhance the relevance of research to communities.

In the end, it is important to ask who benefits from engagement with an intersectional conceptual framework that remains mindful of power and about the fact that in global health research, the relationships around research and engagement are not flat and that some have more power in those circles than others. Within these power differences, in most collaborations, even with activist movements, conceivably, solidarity is a commitment that researchers would (need to) experience. It is hard to see that participants in health research would enroll in research out of a sense of solidarity toward researchers. Engaging with solidarity may be a notion that enhances the already transformative goals of engagement, but to be prescriptive about engagement makes research without engagement more difficult to justify, and misses the point that engagement always has multiple co-existing goals for those who take part.

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Solidarity in Global Health Research—Are the Stakes Equal?

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Global health is in desperate need of greater solidarity between high-income countries (HICs) and low- and middle-income countries (LMICs) as a means to reduce the inequity that pervades all aspects of global health research. At the structural level, the global health research agenda is driven by mostly older men from private funders, global health agencies, governments, and universities in HICs (Global Health 50/50 2020; Pratt et al. 2018; Sridhar 2012). At the operational level, global health researchers are predominantly from HICs with an established history of dropping into LMICs, making use of local infrastructure, personnel, and patients/participants, and failing to provide commensurate remunerations or benefits to these communities (Costello and Zumla 2000; Lancet Global Health 2018; Participants in the 2001 Conference on Ethical Aspects of Research in Developing Countries 2002, 2004). At the dissemination level, we continue to see researchers from HICs disproportionately represented as first or senior authors in prestigious global health journals (Hedt-Gauthier et al. 2019; Mbaye et al. 2019), journals that in turn are predominately based in HICs, not to mention chiefly edited by men (Bhaumik and Jagnoor 2019; Hedt-Gauthier et al. 2019; Nafade et al. 2019). As Seye Abimbola (2019, 4), Editor-in-Chief of *BMJ Global Health*, notes, "In many ways, the growing concerns about imbalances in authorship are a tangible proxy for concerns about power asymmetries in the production (and benefits) of knowledge in global health."

Solidarity, as things currently stand in the context of global health, has its work cut out. As Pratt et al. (2020) suggests, using different forms of community engagement to promote a relationship of solidarity whilst engaging in global health research may provide an avenue to ameliorate this state of affairs. We maintain that solidarity remains a central ethical value for global health, and using community engagement to promote solidarity is, in principle, a worthy endeavor. Nevertheless, we urge extensive vigilance as it risks pushing important differences between researchers and communities outside of the global health researcher's direct line of sight and validating actions that serve researchers more (and, at minimum, differently) than the communities they seek to engage.

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